DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2554 (01/2004)

STATE OF WISCONSIN

HEARING LOSS CERTIFICATION

Telecommunications Assistance Program

Use of form: Completion of this form meets the requirements of s. 46.92, Wisconsin Statutes. Personally identifiable information on this form will be used to determine eligibility for services and will be used only for this purpose.

Name - Applicant (Last, First, Middle)	Telephone Number
Address - (Street, City, State, Zip Code)	Date Examined (mm/dd/yyyy)

I examined the person named above on the date shown and have found him / her to possess a hearing loss significant enough to be considered: (check one)

- ☐ Deaf
- ☐ Severely Hard of Hearing
- ☐ Hard of Hearing

Person Verifying Information

Name	Title (Use one of the titles listed below.)

Address - (Street, City, State, Zip Code)

SIGNATURE - Person Verifying Information	Date Signed (mm/dd/yyyy)

Note: This certificate must be completed by one of the following:

1. Licensed physician
2. Certified audiologist
3. DVR counselor
4. Independent Living Center counselor
5. ODHH Regional Coordinator

Distribution: Mail completed copy to ODHH, Rm. 451, 1 West Wilson St., P.O. Box 7851, Madison, WI 53707-7851